		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040022

Facility Name: CALIFORNIA GARDENS N & REHAB CENTER

Address: 2829 S CALIFORNIA (Number) CHICAGO (City) 60608 (Zip Code)

County: COOK

Telephone Number: (773) 847-8061 **Fax #** (773) 847-1603

IDPA ID Number: 363961687001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	293	Skilled (SNF)	293	106,945	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	293	TOTALS	293	106,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	80,820	5,341	7,579	93,740	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	80,820	5,341	7,579	93,740	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.65%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 3,729

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/01/02 Fiscal Year: 12/01/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CEN # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	327,965	68,883	11,560	408,408		408,408		408,408			1
2	Food Purchase		437,262		437,262	(1,697)	435,565	(249)	435,316			2
3	Housekeeping		60,525	409,280	469,805		469,805		469,805			3
4	Laundry		26,582		26,582		26,582		26,582			4
5	Heat and Other Utilities			200,359	200,359		200,359	766	201,125			5
6	Maintenance	113,216	20,190	173,364	306,770		306,770	1,064	307,834			6
7	Other (specify):*							(96)	(96)			7
8	**TOTAL General Services**	441,181	613,442	794,563	1,849,186	(1,697)	1,847,489	1,485	1,848,974			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	2,601,934	264,390	17,788	2,884,112		2,884,112	(80,826)	2,803,286			10
10a	Therapy	62,345		17,680	80,025		80,025		80,025			10a
11	Activities	80,446	5,155	4,203	89,804		89,804		89,804			11
12	Social Services	183,445		3,014	186,459		186,459		186,459			12
13	Nurse Aide Training	2,895		3,345	6,240		6,240		6,240			13
14	Program Transportation			362	362		362	1,173	1,535			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,931,065	269,545	59,892	3,260,502		3,260,502	(79,653)	3,180,849			16
	C. General Administration											
17	Administrative	157,208		684,509	841,717		841,717	(555,373)	286,344			17
18	Directors Fees											18
19	Professional Services			97,441	97,441		97,441	(4,010)	93,431			19
20	Dues, Fees, Subscriptions & Promotions			65,501	65,501		65,501	(44,822)	20,679			20
21	Clerical & General Office Expenses	157,421	31,517	380,361	569,299		569,299	(173,829)	395,470			21
22	Employee Benefits & Payroll Taxes			580,946	580,946	1,697	582,643		582,643			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,660	11,660		11,660	(6,531)	5,129			24
25	Other Admin. Staff Transportation			1,766	1,766		1,766	198	1,964			25
26	Insurance-Prop.Liab.Malpractice			334,703	334,703		334,703	809	335,512			26
27	Other (specify):*							37,394	37,394			27
28	**TOTAL General Administration**	314,629	31,517	2,156,887	2,503,033	1,697	2,504,730	(746,164)	1,758,566			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,686,875	914,504	3,011,342	7,612,721		7,612,721	(824,332)	6,788,389			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER #0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			113,515	113,515		113,515	(25,230)	88,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,405	63,405		63,405	993,972	1,057,377			32
33	Real Estate Taxes			412,357	412,357		412,357		412,357			33
34	Rent-Facility & Grounds			1,723,973	1,723,973		1,723,973	(1,711,226)	12,747			34
35	Rent-Equipment & Vehicles			6,649	6,649		6,649	10,919	17,568			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,319,899	2,319,899		2,319,899	(731,565)	1,588,334			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	18,617	202,540	138,973	360,130		360,130	294	360,424			39
40	Barber and Beauty Shops	5,755			5,755		5,755		5,755			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,417	160,417		160,417		160,417			42
43	Other (specify):*	39,971			39,971		39,971	(39,971)				43
44	**TOTAL Special Cost Centers**	64,343	202,540	299,390	566,273		566,273	(39,677)	526,596			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,751,218	1,117,044	5,630,631	10,498,893		10,498,893	(1,595,574)	8,903,319			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30,443)	30		9
10	Interest and Other Investment Income	(1,284)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(249)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(8,168)	24		19
20	Contributions	(20,328)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(328,456)	21		24
25	Fund Raising, Advertising and Promotional	(13,242)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(1,131)	20		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(161,506)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (564,807)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,030,767)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,030,767)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,595,574)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
CALIFORNIA GARDENS N & REHAB CENTER

ID# 0040022
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Period Adjustment - Advertising	$ (4,948)	20	1
2	COPE Dues	(5,059)	20	2
3	Pharmacy - Veterans	(80,293)	10	3
4	Veterans Medical Expenses	(350)	10	4
5	Concentrators - Veterans	(183)	10	5
6	Bank Charges	(16,999)	21	6
7	Penalties	(407)	21	7
8	Non-Allowable Legal	(6,497)	19	8
9	Marketing Salary	(18,183)	43	9
10	Clinical Nurse Evaluator	(21,788)	43	10
11	Non-Allowed Nucare Salary	(1,705)	21	11
12	Non-allowed Nucare Payroll Taxes	(146)	27	12
13	Prior Year Advertising Expense	(4,948)	20	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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95				95
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99				99
100				100
101	Total	(161,506)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(249)											(249)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			766									766	5
6	Maintenance			1,064									1,064	6
7	Other (specify):*			(96)									(96)	7
8	**TOTAL General Services**	(249)		1,734									1,485	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(80,826)											(80,826)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			1,173									1,173	14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(80,826)		1,173									(79,653)	16
	C. General Administration													
17	Administrative			(644,130)	104,064	(15,307)							(555,373)	17
18	Directors Fees													18
19	Professional Services	(6,497)		1,595		892							(4,010)	19
20	Fees, Subscriptions & Promotions	(49,656)		1,471		3,363							(44,822)	20
21	Clerical & General Office Expenses	(347,567)		171,526		2,212							(173,829)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(8,168)		1,615		22							(6,531)	24
25	Other Admin. Staff Transportation			198									198	25
26	Insurance-Prop.Liab.Malpractice			809									809	26
27	Other (specify):*	(146)		26,360	6,199	4,981							37,394	27
28	**TOTAL General Administration**	(412,034)		(440,556)	110,263	(3,837)							(746,164)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(493,109)		(437,649)	110,263	(3,837)							(824,332)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(30,443)		5,213									(25,230)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,284)	995,870	(614)									993,972	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,723,973)	12,747									(1,711,226)	34
35	Rent-Equipment & Vehicles			10,919									10,919	35
36	Other (specify):*													36
37	TOTAL Ownership	(31,727)	(728,103)	28,265									(731,565)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			294									294	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(39,971)											(39,971)	43
44	TOTAL Special Cost Centers	(39,971)		294									(39,677)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(564,807)	(728,103)	(409,090)	110,263	(3,837)							(1,595,574)	45

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,723,973	California Gardens Associates		$	$ (1,723,973)	1
2	V	32	Interest Expense		California Gardens Associates		995,870	995,870	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,723,973			$ 995,870	$ * (728,103)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 766	$ 766	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	1,064	1,064	16
17	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	(96)	(96)	17
18	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	1,173	1,173	18
19	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	3,879	3,879	19
20	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	1,595	1,595	20
21	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,471	1,471	21
22	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	171,526	171,526	22
23	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,615	1,615	23
24	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	198	198	24
25	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	809	809	25
26	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	26,360	26,360	26
27	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	5,213	5,213	27
28	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(614)	(614)	28
29	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	12,747	12,747	29
30	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	10,919	10,919	30
31	V	39	ANCILLARY		NUCARE SERVICES CORP.	100.00%	294	294	31
32	V								32
33	V	17	MANAGEMENT FEES	648,009	NUCARE SERVICES CORP.	100.00%		(648,009)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 648,009			$ 238,919	$ * (409,090)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 25,568	$ 25,568	15
16	V	17	ADMIN. - R. BOTTNER		NUCARE SERVICES CORP.	100.00%	30,916	30,916	16
17	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	26,078	26,078	17
18	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,529	2,529	18
19	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	18,973	18,973	19
20	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,246	2,246	20
21	V	27	EMP. BEN. - R. BOTTNER		NUCARE SERVICES CORP.	100.00%	1,206	1,206	21
22	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	1,138	1,138	22
23	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	198	198	23
24	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	1,411	1,411	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 110,263	$ * 110,263	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 21,193	$ 21,193	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		892	892	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		3,363	3,363	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		2,212	2,212	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK		22	22	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		4,981	4,981	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	36,500	CAREPATH HEALTH NETWORK			(36,500)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,500			$ 32,663	$ * (3,837)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$ 85,473	Diamond Insurance	25.00%	$ 85,473	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 85,473			$ 85,473	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CE # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Robert Hartman	Owner	Administrative	57.48%	See Attached	5.29	8.14%	Alloc-Salary	$ 25,568	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	6.4	10.67%	Alloc-Salary	26,078	17-7	2
3	David Hartman	Relative	Administrative	0	See Attached	0.8	1.75%	Alloc-Salary	2,529	17-7	3
4	Eitan Dickman	Administrator	Administrative	0	None	35	100.00%	Alloc-Salary	18,973	17-7	4
5	Eitan Dickman	Administrator	Administrative	0	None	35	100.00%	Salary	94,279	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 167,427		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	752,896	9	$ 5,390	$	106,945	$ 766	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	752,896	9	7,491	(2,814)	106,945	1,064	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	752,896	9	(678)		106,945	(96)	3
4	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	752,896	9	8,255		106,945	1,173	4
5	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	752,896	9	27,305	23,542	106,945	3,879	5
6	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	752,896	9	11,230		106,945	1,595	6
7	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	752,896	9	10,356		106,945	1,471	7
8	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	752,896	9	1,207,546	985,408	106,945	171,526	8
9	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	752,896	9	11,367		106,945	1,615	9
10	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	752,896	9	1,396		106,945	198	10
11	26	INSURANCE	AVAIL. CENSUS DAYS	752,896	9	5,696		106,945	809	11
12	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	752,896	9	185,578		106,945	26,360	12
13	30	DEPRECIATION	AVAIL. CENSUS DAYS	752,896	9	36,699		106,945	5,213	13
14	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	752,896	9	(4,322)		106,945	(614)	14
15	34	BUILDING RENT	AVAIL. CENSUS DAYS	752,896	9	89,738		106,945	12,747	15
16	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	752,896	9	76,871		106,945	10,919	16
17	39	ANCILLARY	AVAIL. CENSUS DAYS	752,896	9	2,070	1,668	106,945	294	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,681,988	$ 1,007,804		$ 238,919	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	9	180,000	720,000	5	25,568	1
2	17	ADMIN. - R. BOTTNER	AVG. HOURS WORKED	50	9	217,649	215,000	7	30,916	2
3	17	ADMIN. - B. CARR	AVG. HOURS WORKED	45	9	183,358	181,000	6	26,078	3
4	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	6	9	18,016	17,000	1	2,529	4
5	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	18,973	17,000	35	18,973	5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	9	15,814		5	2,246	6
7	27	EMP. BEN. - R. BOTTNER	AVG. HOURS WORKED	50	9	8,491		7	1,206	7
8	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	45	9	7,998		6	1,138	8
9	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	6	9	1,411		1	198	9
10	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	1,411		35	1,411	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 653,121	$ 1,150,000		$ 110,263	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	617,442	13	$ 358,512	$ 358,512	36,500	$ 21,193	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	617,442	13	15,097		36,500	892	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	617,442	13	56,887		36,500	3,363	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	617,442	13	37,424		36,500	2,212	4
5	24	SEMINARS	CARE PATH FEES	617,442	13	365		36,500	22	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	617,442	13	84,255		36,500	4,981	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 552,540	$ 358,512		$ 32,663	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd., Suite 105
City / State / Zip Code: Northbrook, IL 6062
Phone Number: ((847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Diamond Insurance	Direct Allocation			$	$		$ 85,473	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 85,473	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CEI # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	California Gardens Assoc.	X					$	$			$ 995,870	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loan	X		Working Capital	Interest Only			3,000,000			63,406	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,000,000			$ 1,059,276	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	Interest Income		X								(1,284)	11
12	Nucare Services		X								(614)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,898)	14
15	TOTALS (line 9+line14)						$	$ 3,000,000			$ 1,057,378	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CEN1 # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	411,060	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	401,667	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,393)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	421,750	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	412,357	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	358,258	8
1998	367,798	9
1999	360,947	10
2000	391,485	11
2001	401,667	12

Accrual: $401,667 X 1.05 = $421,750

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CALIFORNIA GARDENS N & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-25-401-015-0000	Long Term Care Property	$ 401,666.70	$ 401,666.70
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 401,666.70	$ 401,666.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CALIFORNIA GARDENS N & REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0040022

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,844 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	193,025	1987	$ 300,000	1
2					2
3	TOTALS	193,025		$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1981	4,471		20	-		205	9
10	Various			1982	2,319		20	106	106	222	10
11	Various			1983	10,829		20	542	542	1,084	11
12	Various			1984	1,410		20	71	71	142	12
13	Various			1985	17,805		20	100	100	200	13
14	Various			1986	22,863		20	1,143	1,143	2,286	14
15	Various			1987	40,100		20	2,005	2,005	4,010	15
16	Various			1988	2,787		20	139	139	1,963	16
17	Various			1989	3,024		20	151	151	302	17
18	Various			1990	8,652		20	433	433	866	18
19	Various			1991	3,892		20	195	195	390	19
20	Various			1993	24,138		20	1,207	1,207	2,414	20
21	Various			1994	8,195		20	410	410	820	21
22	Various			1995	17,230		20	863	863	6,603	22
23	Various			1996	46,848		20	2,342	2,342	14,752	23
24	Various			1997	70,702		20	3,591	3,591	20,023	24
25	Various			1998	33,854		20	1,695	1,695	7,700	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		4,712,144	136		170	34	591	68
69	Financial Statement Depreciation			51,002			(51,002)		69
70	TOTAL (lines 4 thru 69)		$ 5,031,263	$ 51,138		$ 15,163	$ (35,975)	$ 64,573	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,031,263	$ 51,138		$ 15,163	$ (35,975)	$ 64,573	1
2	WALLPAPER & PAINT	1999	4,750		20	238	238	912	2
3	WALLPAPER	1999	4,343		20	217	217	832	3
4	WALLPAPER	1999	3,284		20	164	164	629	4
5	CARPET COVE BASE	1999	6,083		20	304	304	1,115	5
6	TELEPHONE SYS SERV	1999	1,617		20	81	81	290	6
7	WOOD FLOORING	1999	1,539		20	77	77	270	7
8	WALLPAPER	1999	1,935		20	97	97	340	8
9	WALLPAPER & PAINT	1999	2,300		20	115	115	393	9
10	MINIBLINDS	1999	823		20	41	41	144	10
11	COVE BASE	1999	658		20	33	33	113	11
12	CARPET	1999	561		20	28	28	96	12
13	SIGN BOXES	1999	17,366		20	868	868	3,110	13
14	ALARM SYSTEM	1999	1,146		20	57	57	219	14
15	HEATER & FREEZER	1999	1,444		20	72	72	240	15
16	ELECTRIC, WALL & LAM	1999	14,580		20	729	729	2,430	16
17	WATER MIXING VALVE	1999	956		20	48	48	156	17
18	ELECTRIC CONNECT	1999	1,400		20	70	70	228	18
19	KEY SWITCH, LOCK	1999	645		20	32	32	101	19
20	ELEVATOR WORK	1999	4,677		20	234	234	761	20
21	ELEVATOR WORK	1999	1,261		20	63	63	205	21
22	ALARM SERVICE	1999	764		20	38	38	117	22
23	PHONE SERVICE	1999	1,157		20	58	58	222	23
24	ALARM SERVICE	1999	1,022		20	51	51	166	24
25	GAS WATER HEATER	1999	4,075		20	204	204	629	25
26	SECURITY SYS REP	1999	1,597		20	80	80	267	26
27	TANK WORK	1999	2,430		20	122	122	407	27
28	TANK INSTALLATION	1999	22,123		20	1,106	1,106	3,779	28
29	INST.6 NEW DRAIN OUT	2000	900		20	45	45	135	29
30	INST 3 WINDOWS/1ST F	2000	4,475		20	224	224	672	30
31	FIRST FLOOR RENOVATI	2000	33,510		20	1,676	1,676	4,888	31
32	FIRST FLOOR RENOVATI	2000	7,990		20	400	400	1,167	32
33	42 ENGRAVED SIGNS	2000	1,912		20	96	96	280	33
34	TOTAL (lines 1 thru 33)		$ 5,184,586	$ 51,138		$ 22,831	$ (28,307)	$ 89,886	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,184,586	$ 51,138		$ 22,831	$ (28,307)	$ 89,886	1
2	WALL COVERING	2000	19,422		20	971	971	2,832	2
3	CEILING TILES	2000	1,076		20	54	54	158	3
4	OVER BED LIGHTS	2000	5,563		20	278	278	788	4
5	INSTALL OVER BED LIG	2000	5,775		20	289	289	819	5
6	OVERBED LIGHTS-INSTA	2000	5,933		20	297	297	817	6
7	CUBICLE CURTAINS	2000	19,813		20	991	991	2,725	7
8	RED OAK WOOD DOOR	2000	601		20	30	30	83	8
9	LABOR FOR INSTALL 1S	2000	460		20	23	23	63	9
10	TANK RENTAL	2000	2,500		20	125	125	344	10
11	DRAPERIES	2000	2,012		20	101	101	269	11
12	CABELING FOR CCTV	2000	956		20	48	48	132	12
13	INSTALL CCTV SYSTEM	2000	1,991		20	100	100	267	13
14	HANDRAILS,MOUNTING B	2000	9,909		20	495	495	1,444	14
15	FREIGHT FOR HANDRAIL	2000	210		20	11	11	32	15
16	INSTALL WINDOW TREAT	2000	1,134		20	57	57	133	16
17	MINI BLINDS	2000	110		20	6	6	14	17
18	SHIPPING-DRAPERIES	2000	117		20	6	6	16	18
19	DRAPERY	2000	729		20	36	36	93	19
20	6 MAGNETEK MOTORS	2000	538		20	27	27	70	20
21	FURN & TEST LIGHTS	2000	490		20	25	25	63	21
22	WALL COVERING	2000	4,568		20	228	228	551	22
23	INSTALLED CCTV SYSTE	2000	1,447		20	72	72	198	23
24	SERVICE FIRE DOOR	2000	821		20	41	41	113	24
25	ELEC CABLES TO KITCH	2000	626		20	31	31	85	25
26	INSTALL ALARM SYSTEM	2000	631		20	32	32	88	26
27	TELEPHONE SERV/3 PHA	2000	375		20	19	19	52	27
28	RAN TEL LINE TO BASE	2000	717		20	36	36	96	28
29	RAN LINE TO ACCTG OF	2000	978		20	49	49	127	29
30	LANDCAPING SERV	2000	2,050		20	103	103	249	30
31	CHAIR RAIL & WALL GU	2000	2,964		20	148	148	358	31
32	BORDER	2000	265		20	13	13	30	32
33	FAN COILS FOR A/C UN	2000	516		20	26	26	61	33
34	TOTAL (lines 1 thru 33)		$ 5,279,883	$ 51,138		$ 27,599	$ (23,539)	$ 103,056	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,279,883	$ 51,138		$ 27,599	$ (23,539)	$ 103,056	1
2	LANDCAPING	2000	625		20	31	31	70	2
3	WINDOW & DOOR GLASS	2000	4,900		20	245	245	694	3
4	INST WANDERGUARD SYS	2000	26,630		20	1,332	1,332	3,885	4
5	TREE REMOVAL	2000	690		20	35	35	76	5
6	WALL GUARDS	2000	1,982		20	99	99	215	6
7	KICK PLATES	2000	2,948		20	147	147	319	7
8	WALLPAPER	2000	894		20	45	45	98	8
9	FIRE ALARM REPAIRS	2000	1,117		20	56	56	121	9
10	FIRST FLR REN	2000	7,710		20	386	386	1,126	10
11	NURSES STATION COU	2000	3,020		20	151	151	302	11
12	WATER HEATER	2001	8,920		20	446	446	892	12
13	RUN CBL TO FIRE ALRM	2001	790		20	40	40	80	13
14	TELEPHONE LINE, INST	2001	807		20	40	40	80	14
15	REPLC CAR SILL ON #2	2001	1,580		20	79	79	151	15
16	MOVED ONE HEATER W/A	2001	750		20	38	38	76	16
17	WANDER GUARD DEVICES	2001	686		20	34	34	62	17
18	72 OVRBED LIGHT 3' B	2001	5,332		20	267	267	490	18
19	FPR FIRE PUMP REPAIR	2001	575		20	29	29	48	19
20	WINDOW TREATMENT DR	2001	1,815		20	91	91	159	20
21	WALLCOVERING CORRIDO	2001	6,924		20	346	346	577	21
22	ELECTOMAGNET HOLDER	2001	494		20	25	25	42	22
23	CCD DOME CAMERA W/WI	2001	1,621		20	81	81	135	23
24	DOOR LATCH & LOCK SE	2001	654		20	33	33	52	24
25	WALLGUARDS	2001	4,840		20	242	242	403	25
26	VINYL COVE BASE	2001	141		20	7	7	12	26
27	WALLPAER & OVER BE	2001	6,212		20	311	311	518	27
28	INSTALLED CONCRETE F	2001	11,400		20	570	570	760	28
29	SERVICE ON NURSES CA	2001	926		20	46	46	73	29
30	SERVICE ON ELECTROMA	2001	1,037		20	52	52	82	30
31	RAN PHONE LINES	2001	699		20	35	35	55	31
32	INSTALLED CCTV MONIT	2001	1,391		20	70	70	111	32
33	CEILING TILE	2001	673		20	34	34	43	33
34	TOTAL (lines 1 thru 33)		$ 5,388,666	$ 51,138		$ 33,042	$ (18,096)	$ 114,863	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,388,666	$ 51,138		$ 33,042	$ (18,096)	$ 114,863	1
2	INSTALLED CCTV MONIT	2001	1,440		20	72	72	90	2
3	SERVICE ON NURSES CA	2001	830		20	42	42	53	3
4	SRVC ON BSMNT P.A SY	2001	983		20	49	49	61	4
5	INSTALLED CCTV MNTR	2001	1,724		20	86	86	100	5
6	SRVC ON EXIT DOOR AL	2001	872		20	44	44	51	6
7	NEW FOUNDATION WALL	2001	1,500		20	75	75	81	7
8	CEILING TILE	2001	499		20	25	25	27	8
9	CEILING TILE	2001	461		20	23	23	25	9
10	CEILING TILE	2001	461		20	23	23	25	10
11	INSTALLED CCTV MNTR	2001	1,376		20	69	69	81	11
12	ELECTRICAL WRK ON OU	2001	1,157		20	58	58	63	12
13	PHONE LINE INSTALL	2002	6,351		20	635	635	635	13
14	BOILER	2002	4,779		20	398	398	398	14
15	CANOPY	2002	1,817		20	136	136	136	15
16	WANDERGUARD SYSTEM	2002	1,973		20	132	132	132	16
17	PHONE LINE INSTALL	2002	5,446		20	408	408	408	17
18	RESURFACE LOT/SIDEWALK	2002	25,274		20	562	562	562	18
19	EXIT SIGN	2002	1,275		20	43	43	43	19
20	PHONE LINE INSTALL	2002	1,868		20	47	47	47	20
21	FIRE PUMP	2002	2,730		20	68	68	68	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,451,482	$ 51,138		$ 36,037	$ (15,101)	$ 117,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1977	1977	$ 4,708,760	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nucare Allocation			1997	654	17	20	33	16	171	9
10	Nucare Allocation			1998	573	15	20	29	14	128	10
11	Nucare Allocation			1999	803	69	20	40	(29)	138	11
12	Nucare Allocation			2000	976	25	20	49	(24)	119	12
13	Nucare Allocation			2001	378	10	20	19	9	35	13
14											14
15											15
16											16
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31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,712,144	$ 136		$ 170	$ (14)	$ 591	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 459,440	$ 58,955	$ 46,713	$ (12,242)	10	$ 184,165	71
72	Current Year Purchases	29,570	6,684	2,538	(4,146)	10	2,538	72
73	Fully Depreciated Assets	47,047	176	176		10	47,047	73
74								74
75	TOTALS	$ 536,057	$ 65,815	$ 49,427	$ (16,388)		$ 233,750	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1996 FORD WAGON	1997	$ 21,161	$ 1,775	$ 2,821	$ 1,046	5	$ 21,160	76
77										77
78										78
79										79
80	TOTALS			$ 21,161	$ 1,775	$ 2,821	$ 1,046		$ 21,160	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	6,308,700	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	118,728	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	88,285	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(30,443)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	372,859	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Landscaping Project	$ 8,000	92
93			93
94			94
95		$ 8,000	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NuVision Holding, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			7/1/94	$ 1,723,973			3
4	Additions							4
5	California Gardens Assoc.				(1,723,973)			5
6	Allocation from Nucare				12,747			6
7	TOTAL				$ 12,747 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/1/94
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 1,584,360
13.	/2004	$ 1,584,360
14.	/2005	$ 1,584,360

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 16,109 Description: Copy Machine $5190; Allocation from Nucare $10,919
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	1999 Infiniti I-30	$ 486.00	$ 1,459	17
18					18
19					19
20					20
21	TOTAL		$ 486.00	$ 1,459	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 570	$ 2,010	$	$ 2,580
2	Books and Supplies	191	573		764
3	Classroom Wages (a)				
4	Clinical Wages (b)	724	2,171		2,895
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 1,485	$ 4,754	$	$ 6,239
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,239			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 63,037	$		$ 63,037	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,724			7,724	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			68,212			68,212	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				137,855		137,855	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			18,616			64,685		83,301	13
14	TOTAL			$ 18,616		$ 138,973	$ 202,540		$ 360,129	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	7,967		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,699,425		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	179,161		6
7	Other Prepaid Expenses	16,646		7
8	Accounts Receivable (owners or related parties)	237,431		8
9	Other(specify): See Supplemental Schedule	213,012		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,353,642	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	585,840		15
16	Equipment, at Historical Cost	520,244		16
17	Accumulated Depreciation (book methods)	(559,633)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	84,913		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 631,364	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,985,006	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 978,163	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,000,000		29
30	Accrued Salaries Payable	206,871		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,516		31
32	Accrued Real Estate Taxes(Sch.IX-B)	421,750		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	27,172		35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	182,260		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,847,732	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,847,732	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 137,274	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,985,006	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 767,159	1	
2	Restatements (describe):		2	
3	**Depreciation**	(60,705)	3	
4	**Adjustment to Bad Debt Allowance**	(387,647)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 318,807	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(181,533)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (181,533)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 137,274	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,921,161	1
2	Discounts and Allowances for all Levels	(171,348)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,749,813	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	247,775	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 247,775	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	210,906	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,792	19
20	Radiology and X-Ray		20
21	Other Medical Services	86,790	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 318,488	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,284	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,284	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,317,360	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,849,186	31
32	Health Care	3,260,502	32
33	General Administration	2,503,033	33
	B. Capital Expense		
34	Ownership	2,319,899	34
	C. Ancillary Expense		
35	Special Cost Centers	405,856	35
36	Provider Participation Fee	160,417	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,498,893	40
41	**Income before Income Taxes (line 30 minus line 40)****	(181,533)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (181,533)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,221	$ 76,718	$ 34.54	1
2	Assistant Director of Nursing	1,918	2,233	65,462	29.32	2
3	Registered Nurses	21,754	24,006	670,314	27.92	3
4	Licensed Practical Nurses	39,221	42,213	741,453	17.56	4
5	Nurse Aides & Orderlies	107,934	116,699	1,013,170	8.68	5
6	Nurse Aide Trainees	363	363	2,895	7.98	6
7	Licensed Therapist	494	533	18,617	34.93	7
8	Rehab/Therapy Aides	6,084	6,418	62,345	9.71	8
9	Activity Director	1,909	2,134	21,574	10.11	9
10	Activity Assistants	7,446	8,103	58,872	7.27	10
11	Social Service Workers	5,387	5,947	80,166	13.48	11
12	Dietician	3,997	4,251	78,567	18.48	12
13	Food Service Supervisor					13
14	Head Cook	8,546	9,438	96,006	10.17	14
15	Cook Helpers/Assistants	20,385	22,468	153,392	6.83	15
16	Dishwashers					16
17	Maintenance Workers	5,418	5,968	113,216	18.97	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,904	2,080	94,279	45.33	20
21	Assistant Administrator					21
22	Other Administrative	1,135	1,485	62,929	42.38	22
23	Office Manager					23
24	Clerical	11,456	12,716	157,421	12.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,658	8,098	103,279	12.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,804	3,078	34,817	11.31	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,974	2,105	45,726	21.72	33
34	TOTAL (lines 1 - 33)	259,683	282,557	$ 3,751,218 *	$ 13.28	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,560	01-03	35
36	Medical Director	Monthly	13,500	09-03	36
37	Medical Records Consultant	81	4,033	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,901	10-03	39
40	Physical Therapy Consultant	40	2,101	10a-03	40
41	Occupational Therapy Consultant	180	9,458	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	97	4,203	11-03	44
45	Social Service Consultant	57	3,014	12-03	45
46	Other(specify)				46
47	DD Therapy Consultant	98	6,121	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	553	$ 60,891		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 632	10-03	50
51	Licensed Practical Nurses	113	6,222	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	129	$ 6,854		53

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eitan Dickman	Administrator	0	$ 94,279
Farat Sharif	Administrative	0	32,785
Kathy Brander (Nucare)	Dir of Reg Mgmt	0	14,559
Ray Dolan	VP Risk Mgmt	0	15,585
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 157,208

B. Administrative - Other

Description	Amount
Management Fees - NuCare Services	$ 648,009
Management Fees - Carepath	36,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 684,509

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 25,053
See Attached	Legal	37,968
Purchasing Plus	Purchasing Consultant	900
Personnel Planners	Unemployment Consultant	4,604
See Attached	Computer	28,916
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 97,441

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,404
Unemployment Compensation Insurance	34,990
FICA Taxes	270,755
Employee Health Insurance	73,457
Employee Meals	1,697
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	7,148
Union Health Insurance	71,570
Union Pension Benefits	21,941
Dental/Life Insurance	11,653
Other Employee Benefits	34,048
401K	1,983
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,646

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,652
Health Care Worker Background Check	2,360
(Indicate # of checks performed 322)	
Dues/Subscriptions	7,331
Yellow Page Advertising	1,131
License & Inspections	2,503
Allocation from Nucare	1,471
Allocation from Carepath	3,363
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,131)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,680

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,491
Allocation from Nucare	1,615
Allocation from Carepath	22
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,128

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CALIFORNIA GARDENS N & REHAB CENTER # 0040022 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **IL Council on Long Term Care $16,570**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,071** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
California Gardens Nursing Center #00040022, 7/1/94

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **160,417**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? ____ For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,697** Has any meal income been offset against related costs? **No** Indicate the amount. $ ____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: ____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? ____ If no, please explain. ____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees